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Issue Date: 01 July 2003

In the matter of
Scott A. Woods
Claimant

v.

Case No. 2001-BLA-0518

Clinchfield Coal Co.
Employer

and

Director, Office of Workers'
Compensation Programs
Party in Interest.

DECISION AND ORDER ON REMAND
DENYING BENEFITS

This case was remanded “for further proceedings consistent with [the] opinion” of the Benefits Review Board in an unpublished Decision and Order on February 5, 2003, which affirmed in part and vacated in part my Decision and Order issued on December 18, 2001.

BACKGROUND

The Claimant, Scott A. Woods, filed his initial application for benefits on October 26, 1983 (DX 1). An initial finding of entitlement was made by the District Director on January 29, 1985 and reiterated on May 30, 1985 (DX 22-111A). On June 4, 1985, the Employer, Clinchfield Coal Company, requested reconsideration of the finding of entitlement, or in the alternative, a formal hearing before the Office of Administrative Law Judges (DX 22-111A). Following a formal hearing held on March 4, 1988, Administrative Law Judge T. Eugene Burts issued a Decision and Order, dated July 1, 1988, denying benefits (DX 55).¹ The Claimant thereafter filed a timely appeal with the Benefits Review Board (“BRB”), which subsequently issued a Decision and Order, dated September 27, 1990 (BRB No. 88-2677 BLA), affirming Claimant’s denial of benefits (DX 61).

On July 19, 1991, Claimant filed a Motion for Modification with the District Director (DX 65). Subsequently, Claimant requested a formal hearing (DX 71), which was held before Honorable Joan Huddy Rosenzweig on May 5, 1993 in Abingdon, Virginia. By Decision and

¹ Judge Burts found that the evidence established the existence of pneumoconiosis arising out of Claimant’s coal mine employment pursuant to 20 C.F.R. §§ 718.202(a)(4) and 718.203(b), but concluded that the evidence did not establish total disability pursuant to 20 C.F.R. § 718.204(c).

Order dated March 23, 1994, Judge Rosenzweig denied Claimant's application for benefits (Id.). In denying Claimant's application for benefits, Judge Rosenzweig, despite finding that Claimant's recently submitted medical evidence established a change in conditions, concluded that Claimant failed to establish total disability due to pneumoconiosis pursuant to 20 C.F.R. § 718.204(c) and (b) (DX 22-110). On appeal, the Board affirmed Judge Rosenzweig's finding that a change in condition was established, but remanded the case for her to weigh all of the relevant evidence regarding the exertional requirements of Claimant's coal mine employment and to compare the opinions of Drs. Fino and Branscomb with those requirements. *Woods v. Clinchfield Coal Co.*, BRB No. 94-2311 BLA (Feb. 16, 1995)(unpub.) (DX 22-121). Upon remand, Judge Rosenzweig, after further consideration and analysis, found that, with the exception of lifting 160 pounds² one (1) time per day, Claimant's job was sedentary, sitting during his eight-hour shift (DX 22-119).³ Judge Rosenzweig then concluded that Claimant again failed to establish total disability pursuant to 20 C.F.R. § 718.204(c) and was not entitled to benefits under the Act (DX 22-119).

For the third time, the Board was asked to reconsider an Administrative Law Judge's decision to deny benefits to Claimant. In affirming Judge Rosenzweig's Decision and Order, dated August 12, 1996, the Board held that the administrative law judge reasonably concluded that Claimant's job as a shuttle car operator entailed predominantly light, to sedentary, work with only very limited somewhat heavy exertion (DX 22-121). Moreover, the Board acknowledged that the administrative law judge acted within her discretion in finding the opinions of Drs. Sargent and Fino to be "persuasive," specifically that the opinions were rendered by "pulmonary specialists" who wrote "extremely thorough and well reasoned [reports] consist[ing] of in-depth analyses of the available evidence" (DX 22-121, DX 22-119). As such, the Board affirmed the denial of benefits due to Claimant's failure to establish total respiratory disability pursuant to 20 C.F.R. § 718.204(c).

Claimant filed his most recent duplicate claim⁴ on March 28, 2000, naming Clinchfield Coal Company as the responsible operator (DX 24). Following a formal hearing, I concluded that Claimant demonstrated that he is now totally disabled from a respiratory perspective, thereby establishing that a material change in conditions had occurred since his last application for benefits was denied. Thereafter, I found that Claimant had established that he has pneumoconiosis. I further found that Claimant established that his pneumoconiosis arose out of his coal mine employment and that his total respiratory impairment was due to pneumoconiosis. Based on my determination that he had proven all the elements of entitlement under the Act, I awarded Mr. Woods benefits.

² Claimant testified in his March 3, 1985 deposition that the 160 pounds referred to barrels of oil, which he lifted to waist-level height and pushed onto the shuttle car (EX 6, DX 22-119).

³ Judge Rosenzweig found that Claimant's duties in his shuttle car operator job are most accurately described in the Description of Coal Mine Work and Other Employment form (DX 6).

⁴ The claimant's prior claims are administratively final.

MANDATE ON REMAND

On appeal, the Employer alleged numerous errors, many of which were accepted by the Benefits Review Board. The Board accepted the Employer's contention that I erred in finding that a material change in conditions was established since, when evaluating the newly submitted medical opinions, I failed to accept the previous Administrative Law Judge's findings regarding the physical requirements of Claimant's usual coal mining employment. Because the material change in conditions finding was based on an improper reconsideration of the exertional requirements of Claimant's usual coal mining employment, the Board vacated my finding pursuant to 20 C.F.R. § 725.309(d)(2000) and remanded for further consideration. Upon reconsideration of the new evidence when assessing whether a material change in conditions has been established, the Board pointed out that I must accept the correctness of the previous finding of the specific requirements of Claimant's job as a shuttle car operator (BRB Decision and Order, p. 4).

The Employer next argued that a finding of a material change in conditions is precluded because Drs. Hippensteel and Rasmussen relied on descriptions of Claimant's coal mine work that the previous administrative law judge rejected. The Board rejected this argument and advised that the administrative law judge may compare their opinions with the exertional requirements of Claimant's coal mine employment as found by the first administrative law judge when determining whether total disability, and thus a material change in conditions is established (BRB Decision and Order, p. 4-5).

The Benefits Review Board next accepted the Employer's contention that I did not provide a valid reason for discrediting Dr. Hippensteel's opinion that the Claimant did not have pneumoconiosis. In doing so, the Board stated that I mischaracterized Dr. Hippensteel's opinion when discrediting it as "undermined by false assumptions" and discounting it for reasons that are not in accordance with the law. As a result, the Benefits Review Board vacated my finding pursuant to 20 C.F.R. § 718.202(a)(4). On remand, I am instructed to reconsider the opinion of Dr. Hippensteel (BRB Decision and Order, p. 6).

The Board also accepted the Employer's argument that I did not properly weigh together all relevant evidence of pneumoconiosis. In its decision, the BRB held that my finding of pneumoconiosis was based on the medical opinions alone, without weighing the chest x-rays and medical opinions together. Thus, my finding pursuant to 20 C.F.R. § 718.202(a) was vacated and remanded in order to have all of the relevant evidence weighed together (BRB Decision and Order, p. 7).

The Employer next argued that my mischaracterization of Dr. Hippensteel's opinion also affected my analysis of Dr. Hippensteel's and Dr. Rasmussen's opinions as to disability causation. The Employer further asserted that substantial evidence does not support my finding that Dr. Hippensteel failed to set forth any legitimate reasons for ruling out coal dust exposure as a cause or aggravation of Claimant's total disability. Upon review of Dr. Hippensteel's report and deposition testimony, the Board found that I did not provide a valid rationale for discrediting Dr. Hippensteel's opinion. As a result, the Board vacated my finding pursuant to 20 C.F.R. § 718.204(c) (BRB Decision and Order, p. 7).

Lastly, the Employer asserted that I erred in augmenting benefits for two (2) dependents. The Board advised that, should entitlement be established on remand, I must reconsider whether benefits should be augmented for dependents.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Except as otherwise vacated by the Benefits Review Board, or modified herein, all of the evidence which was previously discussed in the Decision and Order, issued on December 18, 2001, as partially affirmed by the Benefits Review Board, is incorporated herein, thereby obviating the need for a complete repetition of such evidence. Nevertheless, the points raised by the Benefits Review Board's Decision and Order have been resolved, as set forth below, based upon my review and analysis of all the relevant evidence.

As alluded to above, the Employer argued and the Board accepted the contention that I erred in finding a material change in conditions was established because I did not accept the previous administrative law judge's finding regarding the physical requirements of Claimant's usual coal mine employment when the newly submitted medical opinions were reviewed. The Board, citing *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358, 1361 (4th Cir. 1996), further stated that "the Claimant's prior decision denying benefits became final and therefore, that decision and "its necessary factual underpinning" are presumed to be correct for purposes of considering a material change in conditions" (BRB Decision and Order, p. 4). Because my material change in conditions finding was based on an improper reconsideration of the exertional requirements, my finding pursuant to 20 C.F.R. § 725.309(d)(2000) was vacated thereby remanding the case for further consideration.

On remand, I must accept the prior finding as to the specific requirements of claimant's job as a shuttle car operator when making the material change in conditions determination (BRB Decision and Order, p. 4). The Board further advised that I may compare these exertional requirements, as found by the first administrative law judge, with the opinions of Drs. Hippensteel and Rasmussen when determining whether total disability, and thus a material change in conditions is established (BRB Decision and Order, p. 4-5).

In view of the Board's finding that I incorrectly considered Claimant's exertional requirements in my earlier decision, I will again make a determination as to whether Claimant is totally disabled, thereby establishing a material change in conditions pursuant to 20 C.F.R. § 725.309(d)(2000). In a duplicate claim, the threshold issue is whether there has been a material change in conditions since the previous claim was denied.

Total Disability

The first determination must be whether the Claimant is totally disabled. A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(1). Section 718.204(b)(2) provides the following methods for establishing total disability: (1) qualifying pulmonary function tests; (2) qualifying arterial blood gas studies; (3) evidence of cor pulmonale with right-sided congestive heart failure; (4) reasoned medical opinions; and (5) lay testimony.

a. Pulmonary Function Tests

As previously stated, total disability may be established with qualifying pulmonary function studies. The pulmonary function study, also referred to as a ventilatory study or spirometry, measures obstruction in the airways of the lungs. The greater the resistance to the flow of air, the more severe any lung impairment. A pulmonary function study does not indicate the existence of pneumoconiosis; rather, it is employed to measure the level of the miner's disability. In performing the study, the miner is required to blow hard into a mouthpiece which is connected to a flowmeter. The spirometer records the amount of air expired over a period of time onto tracings which must be included in the miner's case record. The regulations require that this study be conducted three (3) times to assess whether the miner exerted optimal effort among trials, *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984), but the Board has held that a ventilatory study which is accompanied by only two (2) tracings is in "substantial compliance" with the quality standards at §§ 718.204(c)(1). *Defore v. Alabama By-Products Corp.*, 12 B.L.R. 1-27 (1988). Furthermore, the administrative law judge may accord lesser weight to those studies where the miner exhibited "poor" cooperation or comprehension. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945 (1984). It is important to realize that, if the miner does have a pulmonary or respiratory impairment, undergoing such test may be very painful, and the miner may be unable to complete the test due to coughing or shortness of breath.

As an individual ages, his or her lung capacity lessens. Differences in lung volume have also been noted between men and women of the same age and height. As a result, tables of data based upon the miner's age, height and gender are used to determine whether the study has produced qualifying results. To qualify under the regulations, the FEV₁ and either the MVV or FVC values must be equal to or less than the appropriate values set out in the tables at 20 C.F.R. Part 718, Appendix B for a miner of similar age, gender and height.⁵

Claimant underwent three pulmonary function tests since his last application for benefits was denied (DX 5, DX 8 and EX 3). Each of Claimant's tests are qualifying under the regulations at 20 C.F.R. § 718.204 (b)(2), App. B (Id). Therefore, based on these qualifying pulmonary function tests, Claimant is totally disabled under the Act.

b. Blood Gas Studies

Section 718.204(b)(2)(ii) provides that a claimant may prove total disability through evidence of qualifying blood gas studies. Moreover, Claimant's arterial blood gas levels must correspond to the values in Appendix C. 20 C.F.R. § 718.204(b)(2). According to Appendix C, for tests conducted at sites up to 2,999 feet above sea level, the sum of Claimant's PCO₂ and PO₂ levels must be equal to or less than 100 mm Hg.

Claimant underwent four (4) blood gas studies since his last application for benefits was denied. Of the four studies, the only study that qualifies Claimant as totally disabled⁶ was performed by Dr. Hippensteel on March 12, 2001 (EX 5). Because of the lapse of time between

⁵ Based upon the record, the Claimant's height is 68.5 inches (average between the three reported heights).

⁶ The sum of Claimant's PCO₂ and PO₂ levels equaled 97.7 mm Hg (EX 5).

Claimant's first study (September 11, 1997) and last study (March 12, 2001), I give very little weight to the first blood gas study performed by Dr. Robinette. As for the two studies sandwiched between Claimant's four (4) blood gas studies, they both produced non-qualifying results (DX 7, DX 8).

In the end, I am left with one (1) qualifying blood gas study, which is the most recent test, and two (2) non-qualifying studies performed simultaneously by Drs. Rasmussen and Michos (DX 7, DX 8 and EX 5). Because none of the three (3) tests, whether looked at separately or coupled together, are persuasive enough, Claimant has failed to carry his burden of establishing total disability pursuant to blood gas study evidence.

c. Evidence of Cor Pulmonale

Under section 718.204(b)(2)(iii), total disability may be proven through evidence establishing cor pulmonale with right-sided congestive heart failure. This section is inapplicable to this claim because the record contains no such evidence.

d. Physician Opinion Evidence

Lastly, the regulations provide that, where total disability cannot be established under paragraphs (c)(1), (2) or (3) or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may nevertheless where a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a respiratory or pulmonary impairment prevents the miner from engaging in his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.204(b)(2)(iv). The claimant must first compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding for total disability is made, thereby shifting the burden to the party opposing entitlement to prove that the claimant is able to perform gainful and comparable and gainful work, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans and Grambrel Co.*, 12 B.L.R. 1-83, 1-87 (1988).

In Mr. Woods' first application for benefits, Administrative Law Judge Rosenzweig found that Claimant's last job usual coal mine work as a shuttle car operator entailed predominantly light to sedentary work, with only very limited somewhat heavy exertion⁷ with the exception of lifting 160 pounds one (1) time per day, was sedentary, with him sitting during his eight (8) hour shift (DX 22-119).

Despite the fact that Claimant's last usual coal mine job, as a shuttlecar operator, can be characterized as predominantly light to sedentary work, I maintain that Mr. Woods has established that he is totally disabled from a respiratory standpoint. As provided in my earlier decision and order, the only newly submitted medical opinions that discuss the issue of total disability are those of Drs. Hippensteel and Rasmussen. In each of their reports, both physicians

⁷ ALJ Rosenzweig based her finding as to Claimant's duties in his shuttle car operator job on Mr. Woods' Description of Coal Mine Work and Other Employment form (DX 6, DX 22-119).

conclude that Claimant is totally disabled from a pulmonary standpoint to the effect that he cannot return to work⁸ (EX 1, DX 6). Furthermore, Dr. Hippensteel, in his deposition, testified that "Claimant has a respiratory impairment that at the time of examination is severe and that this is enough to keep him from going back to his work in the mines" (EX 27). Furthermore, each of these reports are based on medically accepted clinical and laboratory diagnostic testing as provided in the physicians' reports (EX 1, DX 6).

Pursuant to the Board's instruction, I have accepted the specific requirements of Claimant's job as a shuttle car operator, as previously found by Administrative Law Judge Rosenzweig, and compared them with the medical opinions of Drs. Hippensteel and Rasmussen. Because both physicians opined that Claimant is totally disabled due to his respiratory impairment that makes him unable to return to his work in the mines, I find that the preponderance of the evidence establishes that Claimant's pulmonary impairment is such that he is unable to return to his last usual coal mining job.

Having demonstrated that he is now totally disabled from a respiratory perspective, Claimant has established a material change in conditions. According to 20 C.F.R. § 725.309, denial of Claimant's duplicate claim based on the denial of his prior claim is no longer applicable. Instead, I will review the entire record to determine whether Claimant is able to prove all four elements necessary for entitlement of benefits under the Act.

Existence of Pneumoconiosis

As noted previously, the Board vacated my finding that Claimant established the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(4). In doing so, the Board reasoned that I mischaracterized Dr. Hippensteel's medical opinion. On remand, I am instructed to reconsider Dr. Hippensteel's opinion (BRB Decision and Order, p. 6).

In view of the Board's finding that I mischaracterized Dr. Hippensteel's medical opinion in my earlier decision, I will again summarize his findings.

Dr. Hippensteel

Dr. Hippensteel examined the Claimant on March 12, 2001. As a result, Dr. Hippensteel submitted a medical report based on this examination, as well as his review of the information submitted to him by Counsel for the Employer. Included is all the data associated with Claimant's initial application for benefits as well as the data associated with his second application.

In his report, Dr. Hippensteel noted that Claimant worked for a total of 19 years in coal mines, with his last job as a shuttlecar operator. Claimant stated to Dr. Hippensteel that his last job involved lifting 16 gallon oil barrels, 50-pound rock dust bags, roof bolt bundles and had very little walking. Claimant further stated that he stopped work in 1982 when the mines shut down,

⁸ In his medical report, Dr. Hippensteel concluded that the records show that Claimant is now disabled from a pulmonary standpoint, in addition to his other medical problems, so that he cannot return to work (EX 1). Similarly, Dr. Rasmussen concluded in his report that Claimant does not retain the pulmonary capacity to perform his last coal mine employment job (DX 6).

to which he was later told by Dr. Robinette that he should not go back to work because of his breathing (EX 1).

Claimant presented the following complaints: ½ cup a day sputum production that is variable in amount and usually yellow to gray in color; circulatory problems in his lower extremities; arthritis; diabetes which requires medication; high blood pressure; trouble with his nerves when he tries to get off cigarettes; stomach problems which require medication; breathing problems which require medication; pneumonia once a year; and sinus trouble all the time. Claimant's past medical history includes: a stroke in 1989, which affected his memory; a broken left hip surgically repaired five (5) years ago; and a broken left ankle in 1982. As far as his breathing is concerned, Claimant stated that he can only walk 30 feet before getting out of breath. Mr. Woods' also stated that he was told a long time ago by Dr. Robinette that he had a little bit of asthma. Because of his breathing problems, Claimant is on oxygen at two (2) liters per minute, but he can come off for about four (4) to (6) hours per day when necessary, and also uses a nebulizer for bronchodilator medications. Lastly, at the time of examination, Dr. Hippensteel reported that Claimant continued to smoke two (2) packs of cigarettes per day which he has done since the age of 16 (EX 1).

Following physical examination, Dr. Hippensteel reported that Claimant's lungs have mild rhonchi in right upper lobe, with no rales heard elsewhere in the lungs. Dr. Hippensteel interpreted Claimant's chest x-ray as negative for pneumoconiosis with a classification of 0/0, but noted infiltrate, scarring and cavity/bullous formation mainly in the right upper lobe from fungal infection (EX 1).

Dr. Hippensteel reported that Claimant's spirometry showed severe airflow obstruction with minimal improvement post-bronchodilator, with the MMV severely reduced. Dr. Hippensteel further noted that Claimant's lung volumes showed some air trapping with no restriction; that his diffusion is reduced to 47% predicted, but corrects to 62% predicted for volume inhaled (EX 1).

Dr. Hippensteel provided that Claimant's resting arterial blood gases show a pO₂ equal to 60, pCO₂ equal to 38 with barometric pressure reduced to 710 which would make for about an eight (8) mm expected reduction in pO₂ from value at sea level. Furthermore, Claimant's carboxyhemoglobin level was elevated to 2.6%, which is consistent with continued smoking. Claimant exercised for two (2) minutes and seven (7) seconds before stopping because of shortness of breath. His arterial blood gases before ending exercise showed mild to moderate hypoxemia with pO₂ equal 58, pCO₂ 33 and barometric pressure equal to 706 (EX 1).

Based on the data obtained from the physical examination of Claimant and his studies, Dr. Hippensteel concluded that this man has developed significant pulmonary impairment which relates to his severe fungal infection and smoking history rather than his coal dust exposure. Dr. Hippensteel further concluded that there is no evidence of coal workers' pneumoconiosis as a cause for his pulmonary impairment. Claimant also has additional medical problems including arthritis, hypertension, peripheral vascular disease, prior stroke, and trouble with nerves that give him additional impairment that make him unable to go back to his job in the mines from a pulmonary standpoint, and as a whole man. Dr. Hippensteel, however, opined that these problems have not been shown by the data on this examination to be secondary to his coal dust exposure (EX 1).

Following an extensive review of all of the medical records, present and past, submitted in connection with this matter, Dr. Hippensteel concluded that the Claimant suffers from a pulmonary impairment related to chronic bronchitis that was reversible enough at times to show normal function, while at other times showing significant impairment. Dr. Hippensteel opined that there is some possibility that Claimant's allergy problems, as documented in his records, did play a part in this chronic bronchitis, in spite of claims by Mr. Woods that he never had asthma. Dr. Hippensteel noted that the functional disturbances noted in these records regarding his pulmonary status occurred during a time when he continued smoking, in spite of pleadings of his physicians to help himself by ceasing this habit, which his physicians knew was causing him significant problems (EX 1).

Dr. Hippensteel questioned some of the opinions submitted in connection with Mr. Woods' claim – to the effect that these opinions were not supported by the facts in this case. Specifically, Dr. Hippensteel reported that Dr. Robinette admitted in his last office note that Claimant had little insight into his illness, and that Dr. Rasmussen and Dr. Patel, who read the chest x-ray for Dr. Rasmussen, had suboptimal insight into this man's problems as well. According to Dr. Hippensteel, this case does not represent a case of industrial bronchitis secondary to his coal dust exposure and the evidence is against any impairment from his prior coal mining exposure to dust, since he was able to have normal function on pulmonary function studies long after leaving work in the mines. Claimant's continued bronchitis long after leaving work in the mines has a certain association in this case with his continued heavy cigarette smoking, with his wife apparently ascribing a much bigger intake on a daily basis to the Claimant than the Claimant was willing to admit himself. This chronic bronchitis, according to Dr. Hippensteel, associated with his heavy cigarette smoking was associated with variable airflow impairment that was associated with periodic acute infections treated by his physicians, and became even worse at the time he developed pneumonia in December 1999, which was also associated with a worsening of gas exchange, requiring him to use periodic oxygen. This last pneumonia problem, Dr. Hippensteel reported, was not a simple pneumonia that cleared quickly with the usual antibiotic therapy, but was associated with fungal infection that has required six (6) months treatment with a lot of residual damage in his lung as noted on his chest x-ray. The marginal increase in interstitial markings noted on x-rays in the past have mainly been of an irregular type, consistent with somebody with chronic bronchitis and not typical for coal workers' pneumoconiosis. In addition to this fact, Dr. Hippensteel asserted that most of the x-rays in the past were thought to be negative for pneumoconiosis by expert readers. This pattern of x-rays and the abnormalities seen on them, according to Dr. Hippensteel, is additional evidence against coal workers' pneumoconiosis as a cause for these abnormalities or as a cause for progressive pulmonary impairment after leaving work in the mines (EX 1).

In addition to his medical opinion, Dr. Hippensteel offered deposition testimony. In reference to Claimant's assertion that he suffers from pneumoconiosis, Dr. Hippensteel testified as follows:

Q. Doctor, what did you find when you physically examined Mr. Woods?

A. He had mild rhonchi in the right upper lobe where he had this infiltrate on chest x-ray.

Q. Okay. Doctor, I believe that a chest x-ray was taken of Mr. Woods?

A. Yes.

Q. And you personally interpreted that?

A. Yes.

Q. And how did you read that?

A. I thought it was read negative for pneumoconiosis with a classification of 0/0. He had this infiltrate scarring and cavity with bolus formation in the right upper lobe from his prior fungal infection.

Q. Okay. And, Doctor, that was consistent with the history he gave you?

A. That is correct.

Q. Okay. And in reviewing medical records, were the medical records consistent with that history?

A. Yes.

Q. And what did those medical records show?

A. That this man had been treated for a fungal infection by Dr. Robinette and that this therapy had occurred from, I guess, late 1999 through June of 2000 by Dr. Robinette and that this therapy is consistent with the kind of therapy we would give for fungal infections that are non-bacteria and non-tuberculous infections but do respond to a specific antibiotic that was use in this case called Sporanox.

Q. Okay. And will that give x-ray abnormalities that would be -- that would persist over a period of time?

A. Yes. It will leave -- it will cause abnormalities in the first place, and it will leave abnormalities because there is scarring with such infections and cavitation with such infections just like this man had.

Q. Okay. Doctor, the abnormalities you found on the chest x-ray and which are supported by Mr. Woods' history and medical records, are they consistent or related in any way to coal dust exposure?

A. No, they are not.

Q. Doctor, what did Mr. Woods' EKG show?

A. He had left axis deviation with possible left anterior hemiblock as a conduction abnormality in addition to possible right ventricular hypertrophy but showed no ischemic changes with exercise.

Q. Okay. Was there any evidence of the disease of cor pulmonale?

A. The specific changes on his EKG did not make for that diagnosis, no.

Q. Are they (pulmonary function test) diagnostic of any certain type of lung disease or impairment?

A. Well, they are diagnostic that he has obstructive lung disease and no restrictive lung disease, and they aren't diagnostic as to the cause of that obstruction.

Q. Okay. Would they be consistent with emphysema?

A. Yes. It would say that emphysema is a component of this since his diffusion is decreased?

Q. Okay. And, Doctor, what is the most common cause of emphysema?

A. Smoking?

Q. Doctor, can coal dust or pneumoconiosis cause emphysema?

A. Yes.

Q. And what type of emphysema does it cause?

A. It usually causes focal emphysema. There have been some reports about some association with central lobular emphysema in some case study. There is still some controversy about how big a factor that is, but it is considered to be a part at least of coal workers' pneumoconiosis by some people in the field, and there is some literature to support that.

Q. Doctor, is the emphysema related to coal workers' pneumoconiosis clinically significant in most cases?

A. It is not usually significant, but it can be.

Q. Okay. Doctor, do you recognize that coal dust or pneumoconiosis can cause obstructive lung disease?

A. Yes.

Q. Okay. Doctor, when it causes obstructive lung disease, especially to the level seen here in Mr. Woods, would you expect to see other abnormalities on pulmonary function studies as well?

A. Yes, that it would be quite often associated with restrictive lung disease in addition, that it would be associated with abnormalities on the chest x-ray that would be reflective of coal workers' pneumoconiosis. It would be something that would be associated or at least most of the time would be something that would be there and not reflective of other diseases as great as this man had that participated. In other words, I would feel more certain about diagnosing that in the setting where he didn't have scarring from fungal disease and didn't have such a heavy smoking history than I would in calling that alone, especially when I have a negative x-ray for pneumoconiosis. So I think that the total findings in this case make it so that it is not likely related to any coal dust exposure that he has had this obstructive disease develop but is explained well by the other problems that he has had in his life.

Q. Okay. Doctor, have you formed an opinion after examining Mr. Woods as to whether or not Mr. Woods suffers from coal workers' pneumoconiosis?

A. I think that looking at the evidence as a whole and the temporal relationships of the abnormalities and the function and the findings in this case show that he does not have coal workers' pneumoconiosis.

(EX 27). On cross-examination, Dr. Hippensteel's testimony as the existence of pneumoconiosis was as follows:

Q. And in reaching your conclusions in this case with respect to the presence or absence of pneumoconiosis, did you review any positive x-ray interpretations from board certified radiologists?

A. Yes.

Q. And what specifically did those readings indicate with respect to the presence or absence of pneumoconiosis?

A. Well, as I commented peripherally in my just answered question in this deposition, I thought that the radiologist that reviewed the x-ray for Dr. Rasmussen failed to have

information that would have been useful in determining whether there were other abnormalities or other problems that this man had that could have been mistaken for coal workers' pneumoconiosis. So I think that some of these interpretations were falsely arrived at because of a lack of knowledge of what this person had in his history.

Q. Isn't the presence of a fungal infection generally diagnosed through x-ray?

A. Yes, it can be diagnosed in x-ray, although it is more specifically diagnosed by fungal cultures.

Q. And is it your opinion that fungal infection abnormalities show up the same or identical to abnormalities that result from coal dust exposure.

A. The circumstances in this particular case produced an x-ray finding that was mistaken for coal dust exposure when in actuality it was from fungal infection.

Q. Well, in other words, if the abnormalities produced by the fungal infection were mistaken for abnormalities associated with coal dust exposure, then is that the same as saying that the abnormalities from the fungal infection look the same on an x-ray as those findings generally found when looking for coal dust exposure?

A. The abnormalities of granulomatous disease can be mistaken for coal dust exposure, so a specific finding can -- there can be findings in granulomatous disease caused by fungal infections that are like those caused by coal workers' pneumoconiosis, yes.

Q. Well, if you have someone who has a history of coal dust exposure such as in this case and someone who has also had a fungal infection and they look so much alike, how can you tell if all of the abnormalities were made by the fungal infection or if all of the abnormalities were made by the coal dust exposure or if you have a mixture of the two?

A. You can tell by what happens to those abnormalities over time, and the circumstances here is where the medical records over time are of use and the changes in the findings over time are of use. And in this particular case, they came up when he developed a severe infection and they got better as he got treated for that infection. That wouldn't be expected from coal workers' pneumoconiosis, especially since this occurred at a time after he had ceased exposure in the coal mines. So there are temporal relationships that one can look at to see whether it is likely from one cause or another, and that in this particular case was a failure of some physicians to appreciate that and to include that in their conclusions.

Q. Is it your opinion or your understanding that no physician had diagnosed Mr. Woods to suffer from pneumoconiosis after 1982 prior to his episode with the fungal infection?

A. No. I think that most -- most physicians though thought that his chest x-ray was completely negative through that time, but there were some 1/0 readings before then.

Q. Okay. So there were physicians who felt that he had black lung prior to his episode with the fungal infection?

A. Minimal evidence and a marginally positive x-ray, yes.

Q. Okay. So if I understand correctly, the positive x-ray interpretation that you read really didn't have an impact on your opinion?

A. Well, they were included with the other evidence in this case, which included a lot of negative readings of those x-rays and included a lot of other data which showed changes in function after he left work in the mines rather than during the time he was in the mines.

Q. Okay. Now, is a period of 19 years sufficient exposure for a susceptible individual to develop coal workers' pneumoconiosis?

A. Yes.

Q. And would I be correct in stating that coal workers' pneumoconiosis can be diagnosed even in the presence of a negative chest x-ray?

A. Yes.

Q. Can coal workers' pneumoconiosis be diagnosed in the absence of pulmonary fibrosis?

A. Yes.

Q. Is pulmonary fibrosis usually what you would associate with restrictive lung disease?

A. Yes.

Q. Okay. With respect to the presence of central lobular emphysema, earlier you indicated that it was unusual for coal dust to cause central lobular emphysema, but, now, it does happen; is that correct?

A. That is correct.

Q. And it can also cause -- coal dust exposure can also cause clinically significant, in other words, disabling central lobular emphysema?

A. Yes.

Q. Okay. So your definition of coal workers' pneumoconiosis actually doesn't include chronic obstructive pulmonary disease?

A. Yes.

Q. And I believe you also stated earlier that coal workers' pneumoconiosis can continue to progress after the cessation of coal mine employment?

A. Yes.

Q. And that coal workers' pneumoconiosis is generally a permanent condition?

A. Yes.

Q. Can simple coal workers' pneumoconiosis cause a purely obstructive respiratory impairment?

A. Yes.

Q. Now, that's -- so, if I understand the definition of coal workers' pneumoconiosis, it is not always associated with restrictive lung disease; is that true?

A. That's correct.

Q. And as you indicated earlier, the abnormalities on an x-ray or the lack thereof does not necessarily indicate the absence of pneumoconiosis?

A. Yes.

(DX 27).

The regulations define pneumoconiosis broadly:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal" pneumoconiosis.

(1) *Clinical Pneumoconiosis*. “Clinical pneumoconiosis” consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers’ pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis*. “Legal pneumoconiosis” includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease “arising out of coal mine employment” includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, “pneumoconiosis” is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (2002).

This broad definition “effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.” *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68, 2-78 (CA4 1990), 914 4th Cir. 1990), citing *Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980). Thus, asthma, asthmatic bronchitis or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983)(chronic bronchitis secondary to coal dust exposure equivalent to CWP); *Heavilin v. Consolidation Coal Co.*, 6 B.L.R. 1-1209 (B.R.B. 1984)(emphysema held compensable under the Act). Likewise, chronic obstructive pulmonary disease (COPD) may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995)(COPD refers to three disease processes – chronic bronchitis, emphysema and asthma – that are all characterized by airway dysfunction).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by one of the following methods: (1) chest x-ray evidence; (2) autopsy or biopsy; (3) by operation of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability was due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1,

1978); or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion.

As the Board found no error in my findings pursuant to Sections 718.202(a)(1)-(3), a determination as to whether the Claimant suffers from pneumoconiosis pursuant to Section 718.202(a)(4) is necessary. A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative.⁹ 20 C.F.R. § 718.202(a)(4); *Compton v. Beth Energy Mines, Inc. and Director, OWCP*, 98-B.L.A.-14 (1998).

The record contains eighteen (18) medical reports, ranging from chart notes to lengthy and detailed medical reports, submitted by eight (8) physicians. Four (4) of the physicians – Drs. Kanwal, Robinette, Bailey and Rasmussen – diagnosed Claimant as having coal workers’ pneumoconiosis, whereas the remaining four (4) – Drs. Sargent, Fino, Branscomb and Hippensteel – did not.

On November 21, 1983, Dr. Kanwal examined the Claimant and administered a full range of laboratory studies. Additionally, Dr. Kanwal reviewed Claimant’s occupational, social and medical histories. After a review of each, Dr. Kanwal diagnosed Claimant as having coal workers’ pneumoconiosis and chronic bronchitis, of which both relate to his prolonged coal dust exposure (DX 22.17).

Dr. Robinette, Claimant’s treating physician, also diagnosed the Claimant as having coal workers’ pneumoconiosis with a moderately severe ventilatory defect. Furthermore, Dr. Robinette opined that Claimant’s pulmonary disease is irreversible (DX 22.44.2).

Dr. Bailey had the opportunity to examine the Claimant on two (2) occasions. After doing so, Dr. Bailey concluded that Claimant has an advanced pulmonary disease with evidence of severe emphysema and polycythemia. Dr. Bailey added, however, that Claimant’s black lung is probably substantial, at a point in which Claimant should be considered for benefits (DX 22.62.4).

Dr. Rasmussen was the final physician to conclude that Claimant has coal workers’ pneumoconiosis. Before doing so, Claimant performed a physical examination and laboratory tests on Claimant, as well as reviewing Claimant’s chest x-ray and occupational and medical histories. In addition to CWP, Dr. Rasmussen diagnosed Claimant as having chronic obstructive pulmonary disease (COPD)/emphysema (DX 6).

As alluded to above, four (4) physicians concluded that Claimant did not have coal workers’ pneumoconiosis. Despite reading Claimant’s x-rays as positive for CWP, Dr. Sargent ruled out coal workers’ pneumoconiosis and instead diagnosed Claimant as having chronic bronchitis and probably COPD, neither related to Claimant’s exposure to coal dust. In each of his medical reports, Dr. Sargent carefully reviewed Claimant’s medical and occupational histories, as

⁹ The Benefits Review Board has held that the clause in this section “notwithstanding a negative x-ray” must be read to mean “even if there is a negative x-ray.” See *Taylor v. Director, OWCP*, 9-B.L.R. 1-22 BLA (1986). Thus, all physicians’ reports must be considered, including those in which the physician’s opinion is based in part upon a positive x-ray.

well as his x-rays and clinical studies (DX 22.31, DX 22.48). However, I discount Dr. Sargent's medical opinion based on his decision to rule out coal workers' pneumoconiosis even though he interpreted Claimant's x-rays as positive for CWP. A report may be given little weight where it is internally inconsistent and inadequately reasoned. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986).¹⁰

Following his review of his Claimant's x-rays, laboratory studies and medical history, Dr. Fino concluded that Claimant does not suffer from an occupational acquired pulmonary condition. Additionally, Dr. Fino diagnosed Claimant with a moderate obstructive ventilatory defect secondary to smoking. In his January 3, 2000 medical report, which was based on a review of Claimant's CT-scan, Dr. Fino concluded that Claimant had no pleural or parenchymal abnormalities consistent with occupational pneumoconiosis (DX 22.106).

Dr. Branscomb concluded that Claimant suffers from neither clinical, nor legal pneumoconiosis.

Before making his diagnosis, Dr. Branscomb reviewed Claimant's present and past medical histories, occupational history, chest x-rays, physical examinations, laboratory tests and physician depositions. However, Dr. Branscomb, like Dr. Fino, did not physically examine the Claimant before making his diagnosis (DX 22.105).

Most recently, Dr. Hippensteel concluded that Claimant's pulmonary impairments are related to chronic bronchitis and not coal workers' pneumoconiosis. In doing so, Dr. Hippensteel reviewed Claimant's lengthy medical record (physical exams, laboratory studies¹¹, other medical reports, physician depositions and chest x-rays) and his occupational, medical and social histories (EX 1).

In evaluating medical opinions, I must first determine whether opinions are based on objective documentation and then consider whether the conclusions are reasonable in light of that documentation. A well-documented opinion is based on clinical findings, physical examinations, symptoms and a patient's work history. *Fields v. Island Creek Coal Company*, 10 B.L.R. 1-19 (1987); *Hoffman v. B&G Construction Company*, 8 B.L.R. 1-65 (1985). For a medical opinion to be "reasoned," the underlying documentation and data should be sufficient to support the doctor's conclusion. *Fields, supra*. With respect to the existence of pneumoconiosis, I find the preceding medical opinions, with the exception Dr. Sargent's, from the similarly qualified physicians to be well-documented.

Another factor to consider in evaluating conflicting medical reports is the recency of the report. *Clark v. Karst-Robbins Coal Company*, 12 B.L.R. 1-149 (1989)(*en banc*). A medical report containing the most recent physical examination of the miner may be properly accorded greater weight as it is likely to contain a more accurate evaluation of the miner's current condition. *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985). see also *Bates v. Director*,

¹⁰ See also *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999)(*en banc* on recon.)(the Board concluded that it was proper for the administrative law judge to give less weight to the report of Dr. Fino because his opinion was based upon a CT-scan which was not in the record and he did not have the benefit of reviewing the two most recent qualifying pulmonary function studies).

¹¹ EX 3.

OWCP, 7 B.L.R. 1-113 (1984)(more recent report of record entitled to more weight than reports dated eight years earlier); *Kendrick v. Kentland-Elkhorn Coal Co.*, 5 B.L.R. 1-730 (1983). Finally, a medical opinion may be given little weight if it is vague or equivocal. *Griffith v. Director*, *OWCP*, 49 F.3d 184 (6th Cir. 1995); *Justice v. Island Creek Coal Company*, 11 B.L.R. 1-91 (1988).

Based on the time frame that such opinions were rendered, I give less weight to the medical reports of Drs. Kanwal (DX 22-17), Bailey (DX 22.62.7), Robinette (DX 22.44.2, DX 47.1), Sargent (DX 22.31, DX 22.48, DX 22.94), Branscomb (DX 22.105) and Fino (DX 22.106). The dates of these reports range anywhere from seventeen (17) to seven (7) years before the date of Claimant's most recent application for benefits. While I am required to take into account evidence of the entire record, I find that these older medical reports are not as relevant as the medical reports submitted since Claimant's March 28, 2000 application for benefits.

While Dr. Fino concluded in his January 3, 2000 report that Claimant has no pleural or parenchymal abnormalities consistent with occupational pneumoconiosis, he did so after reviewing only a CT-scan without having reviewed any of Claimant's recent laboratory studies. He also did not examine the Claimant. It is for these reasons that I give less weight to Dr. Fino's January 3, 2000 medical report.

In weighing medical evidence, more weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Directo*, *OWCP*, 14 B.L.R. 1-2 (1989). Furthermore, the Fourth Circuit noted the importance of conducting multiple examinations over time in *Adkins v. Director*, *OWCP*, 958 F.2d 49 (4th Cir. 1992), stating that "a comparison of medical reports and tests over a long period of time may conceivably provide a physician with a better perspective than the pioneer physician."

It appears from the record that Dr. Robinette, a "B" reader and certified pulmonologist, is Claimant's treating physician for his lungs (EX 6). According to Dr. Robinette, he has been treating Claimant regularly since 1985 (DX 22-53). And following each of his earlier examinations of Claimant, Dr. Robinette diagnosed Claimant as having coal workers' pneumoconiosis. However, Dr. Robinette's June 12, 2000 medical report (DX 21.2) is silent on the issue of pneumoconiosis. Thus, Dr. Robinette's medical report has no probative value as to the issue of pneumoconiosis. Therefore, despite being Claimant's treating physician, I give little weight to Dr. Robinette's June 12, 2000 report.

Having reconsidered the medical opinions as instructed by the Board, I am again left to determine the issue of pneumoconiosis based on the conflicting opinions of Drs. Hippensteel and Rasmussen. Following a careful review of each physician's medical opinion, I find that Dr. Rasmussen's medical opinion, in that Claimant suffers from pneumoconiosis, is outweighed by the contrary opinion from Dr. Hippensteel. First, Dr. Rasmussen's medical report is based solely on his physical examination of the Claimant and the accompanying chest x-ray and laboratory tests. Conversely, Dr. Hippensteel reviewed the medical evidence of record which enabled him to contrast and compare the differing x-rays, CT scans, lab tests and other physician opinions before offering an opinion of his own. For these reasons, Dr. Hippensteel's medical report is well-documented when compared to the report submitted by Dr. Rasmussen.

Secondly, Dr. Hippensteel provides a more thorough explanation as to how he arrived at his conclusion that Claimant does not suffer pneumoconiosis. For instance, Dr. Hippensteel provided that Claimant has had continued bronchitis long after leaving work in the mines and is associated with his continued heavy cigarette smoking. Dr. Hippensteel goes on to report that Claimant's chronic bronchitis associated with smoking was also associated with periodic acute infections that have been treated by physicians. Dr. Hippensteel further provided that Claimant's last pneumonia bout was not a simple pneumonia, but rather was associated with a fungal infection that required six (6) months of treatment which ultimately resulted in a lot of residual damage in his lung, as noted on the x-ray. Dr. Hippensteel further asserted that the marginal increase in interstitial markings noted on x-rays have mainly been of an irregular type, consistent with chronic bronchitis and not typical for coal workers' pneumoconiosis. In support, Dr. Hippensteel noted that most of the x-rays in Claimant's past were thought to be negative for pneumoconiosis by expert readers (EX 1).

On the other hand, Dr. Rasmussen, in his report, offered the simple diagnosis that Claimant suffers from coal workers' pneumoconiosis as a result of the x-ray changes of pneumoconiosis and the Claimant's 19 years of coal mine employment. Additionally, Dr. Rasmussen diagnosed Claimant with chronic obstructive pulmonary disease/emphysema as a result of his chronic productive cough, airflow obstruction and reduced SBDLCO, as well as a right upper lung mass or neoplasia as shown on the x-ray (DX 6). Besides his notation that Dr. Patel indicated pneumoconiosis s/t with a profusion of 1/1 as well as a right upper lobe mass suggesting neoplasia, Dr. Rasmussen fails to offer any further explanation that supports his finding of pneumoconiosis.

Although a report cannot be discredited simply because a physician did not consider all medical data of record, it is proper to accord greater weight to an opinion which is better supported by the objective medical data of record, i.e., x-ray, blood gas, and ventilatory studies. *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 (1986); *Wetzel v. Director, OWCP*, 8 B.L.R. 1-139 (1985). In making his determination as to the existence of pneumoconiosis, Dr. Rasmussen considered only one (1) of Claimant's chest x-rays, albeit a positive interpretation, one (1) set of laboratory tests and the results of his physical examination of Mr Woods. Unlike Dr. Hippensteel, Dr. Rasmussen was unable to contrast and compare his findings with those of other physicians. As a result, I find that Dr. Rasmussen did not provide an objective medical diagnosis.

Based on the foregoing, I give more weight to the opinion of Dr. Hippensteel who found no evidence of coal workers' pneumoconiosis. I give his report more weight because of his expert qualifications,¹² coupled with the fact that his report is well-documented, reasoned and more thorough.

I accept that the totality of the evidence shows that pneumoconiosis is not established by x-ray evidence. 20 C.F.R. § 718.202(a)(1). Moreover, the Claimant has not provided a documented or a reasoned report from a physician, who, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4).

¹² Dr. Hippensteel is board certified in Internal Medicine and Pulmonary Disease, and his Curriculum Vitae has been admitted into evidence at DX 27.

After a review of all of the evidence, I find that pneumoconiosis has not been established under 20 C.F.R. § 718.202(a)(1)-(4). Therefore, all other issues are moot. As the Claimant has not met his burden under 20 C.F.R. § 718.202 to prove that he has pneumoconiosis, there is no need to discuss any other issue.

CONCLUSION

In view of the above, I find that Claimant has not established that he suffers from pneumoconiosis or that total disability is caused by pneumoconiosis. By failing to do so, Mr. Dye has failed to establish a crucial element in his case. *Oggero v. Director, OWCP*, 7 BLR 1-860 (1985).

Consequently, he has also failed to establish total disability resulting from pneumoconiosis, another crucial element.

ORDER

IT IS ORDERED that the claim for benefits filed by Scott A. Woods is **denied**.

SO ORDERED.

A

DANIEL F. SOLOMON
Administrative Law Judge

Notice of Appeal Rights: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. §725.478 and §725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2605, 200 Constitution Avenue, NW, Washington, DC 20210.